SRP FORT CARSON TBI QUESTIONNAIRE

REV: 24 JUN 2005

NAME (LAST, FIRST, MI)	GRADE	SSN	DO NOT WRITE IN THIS SPACE
			100001
DATE (DDMMYYYY)	DEPLOYING UNIT		
DOB (DD-MM-YYYY)	UIC / MOS		
MOBILIZATION DATE (DD-MM-YYYY)	MOBILIZATION STATION (SRP SITE)		
OPERATION			
COMPONENT ACTIVE RESERVE GUARD			
HOME PHONE			
HOME OF RECORD (ADDRESS)			

COMPLETE PARTS 1 AND 2, MARK EACH ANSWER THAT APPLIES

1. DEPLOYMENT	DEPLOYMENT LOCATIONS		LIST OTHER DEPLOYMENT LOCATIONS IN THIS BOX
○ CONUS	○ IRAQ	○ EUROPE	
○ OCONUS	○ AFGHANISTAN	○ OTHER	

2. DID YOU HAVE *INJURIES* FROM ANY OF THE FOLLOWING WHILE YOU WERE DEPLOYED?
(IF YES, INDICATE THE NUMBER EPISODES TO THE RIGHT OF EACH CAUSE.)

	YES	NO	NUMBER OF EPISODES 1	2	3	4	5 OR MORE
A. FRAGMENT	○	○	○	○	○	○	○
B. BULLETS	○	○	○	○	○	○	○
C. VEHICULAR	○	○	○	○	○	○	○
D. BLAST (ANY)	○	○	○	○	○	○	○
E. FALL	○	○	○	○	○	○	○

F. DATE OF MOST SERIOUS INJURY (DDMMYYYY) _____.____

IF YOU DID NOT REPORT ANY INJURIES IN PART 2, STOP AND DO NOT COMPLETE PARTS 3 AND 4 BELOW.

3. DID ANY OF THE INJURIES YOU RECEIVED WHILE DEPLOYED RESULT IN ANY OF THE FOLLOWING?

	YES	NO
A. BEING DAZED, CONFUSED, OR SEEING STARS	○	○
B. NOT REMEMBERING THE INJURY	○	○
C. LOSS OF CONSCIOUSNESS FOR LESS THAN A MINUTE	○	○
D. LOSS OF CONSCIOUSNESS FOR 1 TO 20 MINUTES	○	○
E. LOSS OF CONSCIOUSNESS FOR MORE THAN 20 MINUTES	○	○
F. SYMPTOMS OF CONCUSSION	○	○
G. HEAD INJURY	○	○
H. NONE OF THE ABOVE	○	○

4. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING SYMPTOMS FROM INJURIES NOTED IN PART #2?
(IF NO, LEAVE BLANK. IF YES, INDICATE BELOW WHEN YOU HAD THE SYMPTOM.)

MARK THE CIRCLES BELOW FOR EACH SYMPTOM THAT WAS A *PROBLEM BEFORE* YOUR INJURIES.

FOR EACH SYMPTOM THAT *WAS A PROBLEM BEFORE* YOUR INJURIES, MARK THE CIRCLES BELOW IF IT *WORSENED AFTER* YOUR INJURIES.

	RIGHT AFTER INJURY	NOW			
A. HEADACHE	○	○	○	○	○
B. DIZZINESS	○	○	○	○	○
C. MEMORY PROBLEMS	○	○	○	○	○
D. BALANCE PROBLEMS	○	○	○	○	○
E. RINGING IN EARS	○	○	○	○	○
F. IRRITABILITY	○	○	○	○	○
G. SLEEP PROBLEMS	○	○	○	○	○
H. OTHER, SPECIFY BELOW	○	○	○	○	○

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THIS PAGE FOR USE BY MEDICAL REVIEWER ONLY

DO NOT WRITE IN THIS SPACE

100001

[redacted]

5. REFERRAL

	PREVIOUS	INDICATED
A. NONE	○	○
B. EDUCATION	○	○
C. PSYCH LEVEL 2	○	○
D. PSYCH LEVEL 3	○	○
E. PRIM CARE	○	○
F. NEURO	○	○
G. NEUROPSYCH	○	○
H. EENT	○	○
I. NEUROSURG	○	○
J. OTHER, SPECIFY BELOW	○	○

6. DATABASE FOR FOLLOW-UP

- ○ PROB TBI - ASYMPTOMATIC F/U 90D
- ○ PROB TBI - CURRENT SYMPTOMS
- ○ NO TBI

COMMENTS

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REVIEWER SIGNATURE _____ DATE _____

AUTHORITY FOR COLLECTION OF INFORMATION: Sections 133, 107-187, 3017, 5031, and 8012, title 10 US Code and Exec Order 9397
PURPOSE: To facilitate health care and identify medical records
ROUTINE USES: To plan, provide, and coordinate health care. To document post deployment health concerns, aid in preventive health, compile statistical data, and evaluate the scope and quality of care.
DISCLOSURE: Mandatory for all military personnel. Voluntary for all other personnel. If the requested information is not provided, comprehensive health care may not be possible, but care will not be denied.

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